

Payment Models Work Group  
Meeting Agenda 1-16-15

**VT Health Care Innovation Project  
 Payment Models Work Group Meeting Agenda  
 Friday, January 16, 2015 1:00 PM – 3:00 PM.  
 DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT  
 Call in option: 1-877-273-4202  
 Conference Room: 2252454**

| <b>Item #</b> | <b>Time Frame</b> | <b>Topic</b>   | <b>Presenter</b>             | <b>Decision Needed?</b>     | <b>Relevant Attachments</b>  |
|---------------|-------------------|--|------------------------------|-----------------------------|--|
| 1             | 1:00 – 1:10       | Welcome and Introductions<br>Approve meeting minutes | Don George                   | Y – Approve minutes         | Attachment 1: Meeting Minutes  |
| 2             | 1:10-1:25         | Updates  | Kara Suter                   | N                           |  |
| 3             | 1:25-2:15         | Medicaid Yr 2 Gate and Ladder                        | Kara Suter and Alicia Cooper | Y- Approval of G&L proposal | Attachment 3a: Memo from QPM to PMWG Re Targets and Benchmarks<br>Attachment 3b: Proposed Changes to Year 2 VMSSP Gate and Ladder            |
| 4             | 2:15-2:50         | Blueprint for Health Presentation                    | Craig Jones                  | N                           | Attachment 4: Community Oriented Health Systems  |
| 5             | 2:50-2:55         | Public Comment                                       |                              | N                           |  |
| 6             | 2:55-3:00         | Next Steps and Action Items                          |                              | N                           | Next Meeting: Monday, February 23, 2015<br>1:00 pm – 3:00 pm<br>EXE - 4th Floor Conf Room, Pavilion Building<br>109 State Street, Montpelier |

# Attachment 1 - Payment Models

Work

Group Minutes 12-01-14

**VT Health Care Innovation Project  
Payment Models Work Group Meeting Minutes**

**Monday, December 1, 2014 2:00 PM – 4:30 PM.  
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT  
Call in option: 1-877-273-4202  
Conference Room: 2252454**

| Item # | Notes  | Next Steps |
|--------|--|------------|
| 1      | Kara Suter called the meeting to order at 2:01pm, announcing that Steve Rauh has resigned his co-chairship, and that Anya Rader-Wallack and Georgia Maheras are recruiting for a replacement. Joelle Judge called the roll. There was not a quorum to approve the minutes of the November meeting.   |            |
| 2      | <p>Kara Suter presented attachment 2. Alicia Cooper summarized the comments received from members of both the PMWG and QPM workgroups regarding the Year 2 Medicaid SSP Gate &amp; Ladder methodology. Discussion in the QPM workgroup on targets and benchmarks for Year 2 Payment measures will continue during their December 22<sup>nd</sup> meeting. After QPM makes recommendations about targets and benchmarks, a proposal regarding the Year 2 Medicaid SSP Gate &amp; Ladder methodology will be shared with this workgroup, hopefully during the January 16<sup>th</sup> meeting.</p> <ul style="list-style-type: none"> <li>• Abe Berman had a question about the process. Kara and Alicia clarified that QPM will be focusing on Targets &amp; Benchmarks, while PMWG will be focusing on the Gate &amp; Ladder methodology to link performance on Payment measures to shared savings eligibility. Any recommendations developed by PMWG regarding the Medicaid Gate &amp; Ladder methodology for Year 2 will then be considered by the Steering Committee and Core Team. Once at the Core Team level, any approved Yr 2 changes will be added to the Yr 2 VMSSP contract amendment and be incorporated into current methodology</li> </ul> |            |
| 3      | <p>Richard Slusky commented that there were discussions with the ACOs and payers, and a recommendation was made that there be no change made in Yr 2 for the Gate &amp; Ladder methodology for the commercial SSP. The gate is already higher for commercial than Medicaid at 55%, and they feel this is still appropriate – especially as there is no data available yet.</p> <ul style="list-style-type: none"> <li>• Julie Wasserman asked about the definition for meaningful improvement. Richard said they have not looked at this yet as it will not be an issue until 2016.</li> <li>• Kara Suter said that comments on this topic are still welcome. Comments may be submitted</li> </ul>   |            |

through the close of business on Monday, December 8<sup>th</sup> ..

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Kara Suter introduced Chris Tompkins and Cindy Thomas from Brandeis. Suggested reading through the memo on own as presentation today will not hit on all of the specifics the memo does. Chris Tompkins presented on attachment 4B, the following were comments or questions from the presentation and memo:

- Heather Bushey asked what was in a PAC and if there was anything sent out to answer that. Will provide the HCl3 web link to workgroup to look through as each episode is different. Table C provides the PAC for each episode: <http://www.hci3.org/content/ecrs-and-definitions>
- Richard Slusky asked about how to read slide 6. Chris Tompkins responded that variation increases from left to right.
- Kara Suter clarified that pregnancy episode includes both vaginal delivery and delivery by C-section, along with prenatal services during pregnancy (while the vaginal delivery episode and the C-section episode include only the delivery event).
- Richard Slusky asked if any cost for pregnancy included child, or just mother. Kara Suter did not believe a child was included in calculations. Chris Tompkins suggested there might be a child involved with total cost of a pregnancy. Michael Bailit said other states are starting to include the child, but this data does not appear to include the child.
- Bard Hill asked if Richard Slusky felt the child should be included or not – Richard felt it made sense to include a child in the calculation of PAC
- Cecelia Wu asked how hypertension is defined. It is a condition, triggered by a diagnosis, and all relevant services are included for a 12 month period. High variation in hypertension is often associated with other illnesses and health issues that come from this disease and patients are going to vary dramatically. Also important to note this data is not risk adjusted for severity.
- Richard Slusky asked if a patient is diagnosed with hypertension but has a stroke, which one will the patient costs be associated to? Kara Suter responded that the cost would likely be under both episodes. Chris Tompkins further explained that it can be all rolled into hypertension if using the highest level of inclusion.
- Susan Aranoff asked how to count chronic conditions, especially if it started before data was collected? A calendar year is used for EOC purposes.
- Cindy Thomas asked why the scale is different from Commercial and Medicaid. Commercial

|   |  |  |
|---|--|--|
|   | <p>payments vary in cost, whereas Medicaid has a set cost – makes sense for a difference in scale.</p> <ul style="list-style-type: none"> <li>• Cindy Thomas asked about identifying absolute dollars – this would have to be pulled from the tableau files or is found in data book previously distributed.</li> </ul>  |  |
| 5 | <p>Kara Suter presented on attachment 5, and suggested the formation of an EOC sub-group to continue this work in more detail. The following were comments or questions on the presentation.</p> <ul style="list-style-type: none"> <li>• Chris Tompkins clarified that HCl3 data does have risk adjustment model in place if chosen</li> <li>• Richard Slusky commented that most interest will likely come from the providers, they will want to more fully understand the potential of this information and have detail for specific episodes. This sub-group will be led by staff to drill down on existing questions with sub-group members. Staff will start analytic work, with RFP to continue and expand on work done by sub-group. Much of the specific information on episodes is in the Tableau files that the staff has access to.</li> <li>• Bard Hill asked if Medicare will also be included in this advancement of work, as it might be beneficial to have the full spectrum of patients to analyze. Kara Suter replied that this level of detail is something that the sub-group will work on, and make recommendations on – possibly down to payer level.</li> <li>• Purpose of Episodes in going forward? Kara Suter responded that this will most likely inform peer to peer learning and care delivery transformation instead of a new payment model construct at this time.</li> <li>• Comments and recommendations to <a href="mailto:Amanda.ciecior@state.vt.us">Amanda.ciecior@state.vt.us</a> by December 15</li> </ul> |  |
| 6 |  |  |
| 7 | <p>January’s meeting will approve previous two months of PMWG meeting minutes.</p>   | <p>Next Meeting:<br/> Friday, January 16, 2015<br/> DVHA Large Conference Rm<br/> 312 Hurricane Lane,<br/> Williston</p> |

# VHCIP PM Work Group Participant List

Attendance:

12/1/2014

|    |                  |
|----|------------------|
| C  | Chair            |
| IC | Interim Chair    |
| M  | Member           |
| MA | Member Alternate |
| A  | Assistant        |
| S  | Staff/Consultant |
| X  | Interested Party |

| First Name | Last Name  |        | Organization                                       | Pymt Models |
|------------|------------|--------|--|-------------|
| April      | Allen      |        | AHS - DCF  | X           |
| Susan      | Aranoff    | x      | AHS-DAIL   | X           |
| Carmone    | Austin     |        | MVP Health Care                                    | M           |
| Ena        | Backus     |        | GMCB   | X           |
| Melissa    | Bailey     |        | VT care partners / VT care network                 | X           |
| Michael    | Bailit     |        | SOV Consultant - Bailit-Health Purchasing          | X           |
| Susan      | Barrett    |        | GMCB   | X           |
| Anna       | Bassford   |        | GMCB   | A           |
| Abe        | Berman     | Phone  | OneCare Vermont                                    | X           |
| Susan      | Besio      |        | SOV Consultant - Pacific Health Policy Group       | X           |
| Martha     | Buck       |        | Vermont Association of Hospital and Health Systems | A           |
| Heather    | Bushey     | v None | Planned Parenthood of Northern New England         | M           |
| Gisele     | Carbonneau |        | HealthFirst  | A           |
| Amanda     | Ciecior    |        | AHS - DVHA   | S           |
| Lori       | Collins    |        | AHS - DVHA   | X           |
| Amy        | Coonradt   |        | AHS - DVHA   | X           |
| Alicia     | Cooper     |        | AHS - DVHA   | S           |
| Michael    | Counter    |        | Visiting Nurse Association & Hospice of VT & NH    | X           |
| Diane      | Cummings   | v ✓    | AHS - Central Office                               | M           |
| Michael    | Curtis     | ✓      | Washington County Mental Health Services Inc.      | M           |
| Danielle   | DeLong     |        | AHS - DVHA   | X           |

|           |             |                    |  |      |
|-----------|-------------|--------------------|--|------|
| Mike      | DelTrecco   | <i>None</i>        | Vermont Association of Hospital and Health Systems | M    |
| Michael   | Donofrio    |                    | GMCB   | X    |
| Kathleen  | Fish        |                    | MVP Health Care                                    | X    |
| Katie     | Fitzpatrick |                    | Bi-State Primary Care                              | A    |
| Erin      | Flynn       | <i>[Signature]</i> | AHS - DVHA   | S    |
| Catherine | Fulton      | <i>[Signature]</i> | Vermont Program for Quality in Health Care         | M    |
| Joyce     | Gallimore   | <i>[Signature]</i> | Bi-State Primary Care/CHAC                         | MA/M |
| Lucie     | Garand      |                    | Downs Rachlin Martin PLLC                          | X    |
| Andrew    | Garland     |                    | MVP Health Care                                    | X    |
| Christine | Geiler      |                    | GMCB   | S    |
| Don       | George      |                    | Blue Cross Blue Shield of Vermont                  | C    |
| Carrie    | Germaine    |                    | AHS - DVHA   | X    |
| Jim       | Giffin      |                    | AHS - Central Office                               | X    |
| Al        | Gobeille    |                    | GMCB   | X    |
| Bea       | Grause      |                    | Vermont Association of Hospital and Health Systems | MA   |
| Lynn      | Guillett    |                    | Dartmouth Hitchcock                                | M    |
| Mike      | Hall        |                    | Champlain Valley Area Agency on Aging              | M    |
| Heidi     | Hall        |                    | AHS - DMH  | M    |
| Janie     | Hall        |                    | OneCare Vermont                                    | A    |
| Thomas    | Hall        |                    | Consumer Representative                            | M    |
| Bryan     | Hallett     |                    | GMCB   | X    |
| Paul      | Harrington  |                    | Vermont Medical Society                            | M    |
| Carrie    | Hathaway    |                    | AHS - DVHA   | X    |
| Carolynn  | Hatin       |                    | AHS - Central Office - IFS                         | X    |
| Erik      | Hemmett     |                    | Vermont Chiropractic Association                   | X    |
| Selina    | Hickman     |                    | AHS - DVHA   | X    |
| Bard      | Hill        | <i>[Signature]</i> | AHS - DAIL   | M    |
| Churchill | Hindes      |                    | OneCare Vermont                                    | X    |
| Con       | Hogan       |                    | GMCB   | X    |
| Nancy     | Hogue       |                    | AHS - DVHA   | X    |

|         |            |   |   |     |
|---------|------------|---|---|-----|
| Craig   | Jones      | ✓   | AHS - DVHA - Blueprint                            | MA  |
| Pat     | Jones      |    | GMCB  | MA  |
| Joelle  | Judge      |   | UMASS   | S   |
| Kevin   | Kelley     |   | CHSLV   | X   |
| Melissa | Kelly      |   | MVP Health Care                                   | X   |
| Sarah   | King       |   | Rutland Area Visiting Nurse Association & Hospice | M   |
| Kelly   | Lange      | ✓   | Blue Cross Blue Shield of Vermont                 | M   |
| Georgia | Maheras    | ✓   | AOA   | S   |
| Mike    | Maslack    |   |   | X   |
| John    | Matulis    |   |   | X   |
| James   | Mauro      |   | Blue Cross Blue Shield of Vermont                 | MA  |
| Alexa   | McGrath    |   | Blue Cross Blue Shield of Vermont                 | A   |
| Sandy   | McGuire    | <i>Phone</i>  | HowardCenter for Mental Health                    | M   |
| Todd    | Moore      |   | OneCare Vermont                                   | M   |
| Jessica | Oski       |   | Vermont Chiropractic Association                  | MA  |
| Annie   | Paumgarten | <i>Anne Paumgarten</i>  | GMCB  | X   |
| Tom     | Pitts      |   | Northern Counties Health Care                     | M   |
| Luann   | Poirer     | <i>Luann Poirer</i>   | AHS - DVHA  | X   |
| Paul    | Reiss      |   | Accountable Care Coalition of the Green Mountains | M   |
| Lila    | Richardson | <i>Phone</i>  | VLA/Health Care Advocate Project                  | M   |
| Howard  | Schapiro   |   | University of Vermont Medical Group Practice      | M   |
| Ken     | Schatz     |   | AHS - DCF   | X   |
| Rachel  | Seelig     | ✓   | VLA/Senior Citizens Law Project                   | MA  |
| Julia   | Shaw       | ✓   | VLA/Health Care Advocate Project                  | M   |
| Tom     | Simpatico  |   | AHS - DVHA  | X   |
| Ted     | Sirota     |   | Northwestern Medical Center                       | M   |
| Richard | Slusky     |  | GMCB  | S/M |
| Jeremy  | Ste. Marie |   | Vermont Chiropractic Association                  | M   |
| Kara    | Suter      | <i>KSF</i>  | AHS - DVHA  | S/M |
| Beth    | Tanzman    |   | AHS - DVHA - Blueprint                            | X   |

|         |           |                    |   |    |
|---------|-----------|--------------------|---|----|
| Anya    | Wallack   |                    | SIM Core Team Chair   | X  |
| Marlys  | Waller    | <i>12/1/2011</i>   | Vermont Council of Developmental and Mental Health Services | X  |
| Julie   | Wasserman | <i>W</i>           | AHS - Central Office  | X  |
| Spenser | Weppler   | <i>SW</i>          | GMCB  | S  |
| Kendall | West      |                    |   | X  |
| Bradley | Wilhelm   |                    | AHS - DVHA  | X  |
| Sharon  | Winn      |                    | Bi-State Primary Care                                       | M  |
| Cecelia | Wu        | <i>[Signature]</i> | AHS - DVHA  | X  |
| Erin    | Zink      |                    | MVP Health Care   | X  |
| Marie   | Zura      |                    | HowardCenter for Mental Health                              | MA |
|         |           |                    |   | 91 |

James Westrich *[Signature]* AHS-DVHA X  
 Sean Skafelstad ✓  
 Chris Tompkins ✓ AHS Branders

# VHCIP PM Work Group Member List

Roll Call: 12/1/2014

*\* Did not have a quorum = no vote*

| Member     |             | Member Alternate |           | Minutes |  | Organization                                       |
|------------|-------------|------------------|-----------|---------|--|--|
| First Name | Last Name   | First Name       | Last Name |         |  |  |
| Carmone    | Austin      |                  |           |         |  | MVP Health Care                                    |
| Heather    | Bushey ✓    |                  |           |         |  | Planned Parenthood of Northern New England         |
| Diane      | Cummings ✓  |                  |           |         |  | AHS - Central Office                               |
| Michael    | Curtis      |                  |           |         |  | Washington County Mental Health Services Inc.      |
| Mike       | DeTrecco ✓  | Bea              | Grause    |         |  | Vermont Association of Hospital and Health Systems |
| Catherine  | Fulton ✓    |                  |           |         |  | Vermont Program for Quality in Health Care         |
| Joyce      | Gallimore ✓ |                  |           |         |  | CHAC   |
| Lynn       | Guillett    |                  |           |         |  | Dartmouth Hitchcock                                |
| Heidi      | Hall        |                  |           |         |  | AHS - DMH  |
| Mike       | Hall        |                  |           |         |  | Champlain Valley Area Agency on Aging              |
| Thomas     | Hall        |                  |           |         |  | Consumer Representative                            |
| Paul       | Harrington  |                  |           |         |  | Vermont Medical Society                            |
| Bard       | Hill ✓      |                  |           |         |  | AHS - DAIL   |
| Sarah      | King        |                  |           |         |  | Rutland Area Visiting Nurse Association & Hospice  |
| Kelly      | Lange       | James            | Mauro     |         |  | Blue Cross Blue Shield of Vermont                  |
| Sandy      | McGuire ✓   | Marie            | Zura      |         |  | HowardCenter for Mental Health                     |

|         |              |         |           |  |   |
|---------|--------------|---------|-----------|--|---|
| Todd    | Moore        |         |           |  | OneCare Vermont                                   |
| Tom     | Pitts        |         |           |  | Northern Counties Health Care                     |
| Paul    | Reiss        |         |           |  | Accountable Care Coalition of the Green Mountains |
| Lila    | Richardson ✓ | Rachel  | Seelig    |  | VLA/Health Care Advocate Project                  |
| Howard  | Schapiro ✓   |         |           |  | University of Vermont Medical Group Practice      |
| Julia   | Shaw ✓       |         |           |  | VLA/Health Care Advocate Project                  |
| Ted     | Sirota       |         |           |  | Northwestern Medical Center                       |
| Richard | Slusky ✓     | Pat     | Jones ✓   |  | GMCB  |
| Jeremy  | Ste. Marie   | Jessica | Oski      |  | Vermont Chiropractic Association                  |
| Kara    | Suter ✓      | Craig   | Jones     |  | AHS - DVHA  |
| Sharon  | Winn         | Joyce   | Gallimore |  | Bi-State Primary Care                             |
|         | 27           |         | 8         |  |   |

a

# Attachment 3a - Memo from QPM to PMWG Re Targets and Benchmarks

## MEMO

DATE: December 29, 2014

TO: VHCIP Payment Models Work Group

FROM: VHCIP Quality & Performance Measures Work Group

RE: Request for Input – Year 2 ACO Payment Measure Targets & Benchmarks

In response to the Payment Models Work Group's request for input regarding the selection of benchmarks and the setting of performance targets for the Year 2 ACO Payment Measures used for the Commercial and Medicaid Shared Savings Programs, the Quality and Performance Measures Work Group members voted in favor (with 2 votes in opposition) of the following recommendations:

### Year 2 Benchmarks:

- Use national HEDIS benchmarks for all measures for which they are available; use ACO-specific change-over-time improvement targets when national benchmarks are unavailable:

| Year 2 Payment Measure |   | Medicaid SSP  | Commercial SSP  |
|------------------------|---|---|---|
| Core-1                 | Plan All-Cause Readmissions   | Improvement targets based on ACO-specific Year 1 Medicaid SSP performance | National commercial HEDIS benchmarks  |
| Core-2                 | Adolescent Well-Care Visits   | National Medicaid HEDIS benchmarks  | National commercial HEDIS benchmarks  |
| Core-3                 | Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)                            | National Medicaid HEDIS benchmarks  | National commercial HEDIS benchmarks  |
| Core-4                 | Follow-Up After Hospitalization for Mental Illness: 7-day   | National Medicaid HEDIS benchmarks  | National commercial HEDIS benchmarks  |
| Core -5                | Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) | National Medicaid HEDIS benchmarks  | National commercial HEDIS benchmarks  |
| Core-6                 | Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis  | National Medicaid HEDIS benchmarks  | National commercial HEDIS benchmarks  |
| Core-7                 | Chlamydia Screening in Women  | National Medicaid HEDIS benchmarks  | National commercial HEDIS benchmarks  |
| Core-8                 | Developmental Screening in the First Three Years of Life  | Improvement targets based on ACO-specific Year 1 Medicaid SSP performance | NA  |
| Core-12                | Ambulatory Care Sensitive Condition Admissions: PQI Composite   | Improvement targets based on ACO-specific Year 1 Medicaid SSP performance | Improvement targets based on ACO-specific Year 1 commercial SSP performance |
| Core-17                | Diabetes Mellitus: HbA1c Poor Control (>9.0%)   | National Medicaid HEDIS benchmarks  | National commercial HEDIS benchmarks  |

## Year 2 Performance Targets

- Use the same methodology that was used in Year 1 for assigning points for performance, such that ACOs may earn a maximum of 3 points for each Payment measure:

| National HEDIS Benchmarks   |          | Improvement Targets: Change Relative to Historic Performance |          |
|-----------------------------|----------|--|----------|
| 25 <sup>th</sup> Percentile | 1 Point  | Statistically significant decline                            | 0 Points |
| 50 <sup>th</sup> Percentile | 2 Points | Statistically same   | 2 Points |
| 75 <sup>th</sup> Percentile | 3 Points | Statistically significant improvement                        | 3 Points |



# Attachment 3b - Proposed Changes to Year 2 VMSSP Gate and Ladder

## Proposed Year 2 VMSSP Gate & Ladder Methodology

Based on feedback received during the public comment period and recommendations from the Quality and Performance Measures Work Group regarding payment measure targets and benchmarks, as well as recent changes to the Medicare Shared Savings Program, the PMWG co-chairs and staff propose the following changes to the Gate & Ladder methodology for Year 2 of the Vermont Medicaid Shared Savings Program (VMSSP). These proposed changes:

1. **Increase the minimum quality performance threshold for shared savings eligibility;**
2. **Include the use of absolute points earned in place of a percentage of points earned to eliminate the need for rounding; and**
3. **Allow ACOs to earn “bonus” points for significant quality improvement in addition to points earned for attainment of quality relative to national benchmarks.**

The proposed framework assumes that the VMSSP in Year 2 will use the 10 measures approved for Payment by the VHCIP Core Team and the GMCB, and that ACOs will be eligible to earn a maximum of 3 points per measure for a total of 30 possible points. ACOs would have to earn at least 16 out of 30 points to be eligible for any earned shared savings. If an ACO earns 24 or more points, they would be eligible to receive 100% of earned shared savings.

| Points Earned (out of 30 possible points) | Percentage of Points Earned | Percentage of Earned Shared Savings |
|---|-----------------------------|-------------------------------------|
| 16-17                                     | 53.3-56.7                   | 75                                  |
| 18  | 60.0                        | 80                                  |
| 19-20                                     | 63.3-66.7                   | 85                                  |
| 21  | 70.0                        | 90                                  |
| 22-23                                     | 73.3-76.7                   | 95                                  |
| ≥24                                       | ≥80.0                       | 100                                 |

In addition to earning points for attainment of quality relative to national benchmarks, ACOs would be eligible to earn one additional point for every measure that is compared to a national benchmark for which they improved significantly relative to the prior program year. “Bonus” improvement points will not be available for measures that already use ACO-specific improvement targets instead of national benchmarks (see table below). As such, an ACO could earn up to 7 “bonus” points for improvement; however, no ACO may earn more than the maximum 30 possible points.

This approach will further strengthen the incentives for quality improvement in the VMSSP by providing ACOs with both external quality attainment targets (in the form of national benchmarks) and internal quality improvement targets (by rewarding change over time).

| Year 2 Payment Measure |   | VMSSP Benchmark Method  | Eligible for “Bonus” Improvement Point |
|------------------------|---|---|--|
| <b>Core-1</b>          | Plan All-Cause Readmissions   | Improvement targets based on ACO-specific Year 1 Medicaid SSP performance |  |
| <b>Core-2</b>          | Adolescent Well-Care Visits   | National Medicaid HEDIS benchmarks  | X                                      |
| <b>Core-3</b>          | Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)                            | National Medicaid HEDIS benchmarks  | X                                      |
| <b>Core-4</b>          | Follow-Up After Hospitalization for Mental Illness: 7-day   | National Medicaid HEDIS benchmarks  | X                                      |
| <b>Core -5</b>         | Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) | National Medicaid HEDIS benchmarks  | X                                      |
| <b>Core-6</b>          | Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis  | National Medicaid HEDIS benchmarks  | X                                      |
| <b>Core-7</b>          | Chlamydia Screening in Women  | National Medicaid HEDIS benchmarks  | X                                      |
| <b>Core-8</b>          | Developmental Screening in the First Three Years of Life  | Improvement targets based on ACO-specific Year 1 Medicaid SSP performance |  |
| <b>Core-12</b>         | Ambulatory Care Sensitive Condition Admissions: PQI Composite   | Improvement targets based on ACO-specific Year 1 Medicaid SSP performance |  |
| <b>Core-17</b>         | Diabetes Mellitus: HbA1c Poor Control (>9.0%)   | National Medicaid HEDIS benchmarks  | X                                      |

Note: Core-1, Core-8, and Core-12 will be ineligible for additional improvement points because these measures are already using ACO-specific change-over-time improvement targets. If national Medicaid benchmarks become available for any of these measures in future, the measures may then become eligible for additional improvement points.

**Example**

| Year 2 Payment Measure |   | Year 1 | Y1 Attainment Points | Year 2 | Y2 Attainment Points | Y2 Improvement Points |
|------------------------|---|--------|----------------------|--------|----------------------|-----------------------|
| <b>Core-1</b>          | Plan All-Cause Readmissions   | 15.4   | 2                    | 15.2   | 2                    |                       |
| <b>Core-2</b>          | Adolescent Well-Care Visits   | 50.9   | 2                    | 57.7   | 2                    | 1                     |
| <b>Core-3</b>          | Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)                            | 75.9   | 0                    | 80.4   | 1                    | 1                     |
| <b>Core-4</b>          | Follow-Up After Hospitalization for Mental Illness: 7-day   | 33.6   | 1                    | 34.8   | 1                    | 0                     |
| <b>Core -5</b>         | Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) | 52.4   | 3                    | 49.5   | 3                    | 0                     |
| <b>Core-6</b>          | Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis  | 27.3   | 2                    | 29.7   | 2                    | 0                     |
| <b>Core-7</b>          | Chlamydia Screening in Women  | 47.0   | 0                    | 47.6   | 0                    | 0                     |
| <b>Core-8</b>          | Developmental Screening in the First Three Years of Life  | 28.2   | 2                    | 36.3   | 3                    |                       |
| <b>Core-12</b>         | Ambulatory Care Sensitive Condition Admissions: PQI Composite   | 18.8   |                      | 17.2   | 2                    |                       |
| <b>Core-17</b>         | Diabetes Mellitus: HbA1c Poor Control (>9.0%)   | 43.1   |                      | 38.9   | 2                    | 1                     |
| <b>Sub-Total</b>       |   |        | <b>12</b>            |        | <b>18</b>            | <b>3</b>              |
| <b>Total Points</b>    |   |        | <b>12/24</b>         |        | <b>21/30</b>         |                       |

Statistically significant improvement in Year 2 relative to Year 1 for three eligible measures results in the ACO being awarded 3 “bonus” improvement points. These points are added to the 18 points the ACO receives for quality performance relative to benchmarks, yielding a total of 21 points out of the total possible 30 points.

In the case of Core-3 (LDL-C Screening), the ACO improves from below the national 25<sup>th</sup> percentile to the national 25<sup>th</sup> percentile, and therefore earns a point for attaining a higher target relative to national benchmarks. This improvement also represents significant improvement relative to the ACO’s performance in the prior year, resulting in an additional improvement point for this measure.

In the case of Core-2 (Adolescent Well-Care Visits), the ACO does not improve enough to meet the national 75<sup>th</sup> percentile, but achieves significant improvement relative to the ACO’s performance in the prior year. Thus, the ACO is still awarded for significant improvement, and continues to have an incentive to improve relative to national benchmarks.

### ***Methodological Considerations***

This methodology would award an ACO up to 1 additional bonus point for quality performance improvement on each Payment measure that is being compared to a National benchmark. These bonus points would be added to the total points that the ACO achieved for each Payment measure based on the ACO's performance relative to National benchmarks. Under this proposal, the total possible points that could be achieved, including up to 7 bonus points, could not exceed the current maximum 30 total points achievable.

For each qualifying measure, the state or its designee would determine whether there was a significant improvement or decline between the performance year and the prior year by applying statistical significance tests<sup>1</sup>, assessing how unlikely it is that the differences of a magnitude as those observed would be due to chance when the performance is actually the same. Using this methodology, we can be certain at a 95 percent confidence level that statistically significant changes in an ACO's quality measure performance for the performance year relative to the prior program year are not simply due to random variation in measured populations between years.

The awarding of bonus points would be based on an ACO's net improvement on qualifying Payment measures and would be calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. Bonus points would be neither awarded nor subtracted for measures that were significantly the same. The awarding of bonus points would not impact how ACOs are separately scored on Payment measure performance relative to national benchmarks.

Consistent with the current VMSSP methodology, the total points earned for Payment measures, including any bonus quality improvement points, would be summed to determine the final overall quality performance score and savings sharing rate for each ACO.

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<sup>1</sup> VMSSP would use the same methodology for calculating significance (t-test) as MSSP.

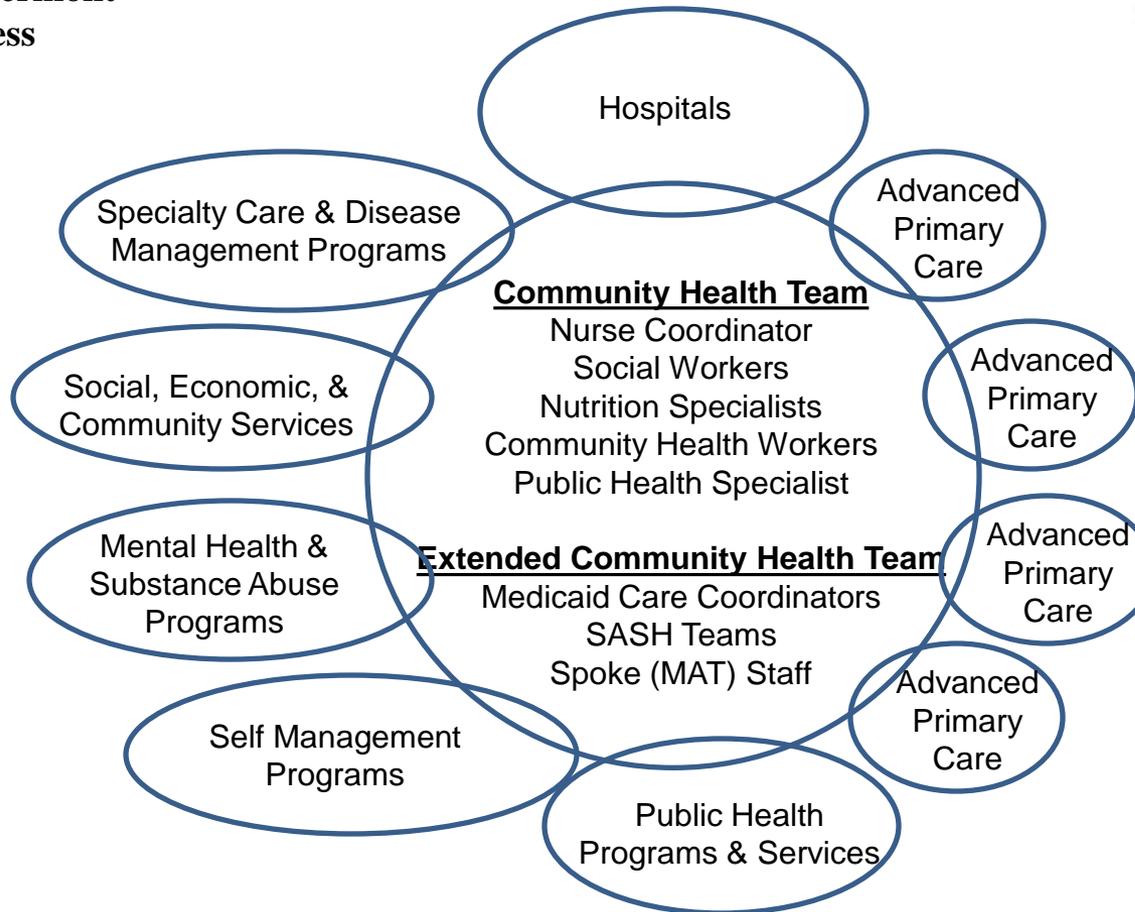


# Attachment 4 - Community Oriented Health Systems

# **Community Oriented Health Systems**

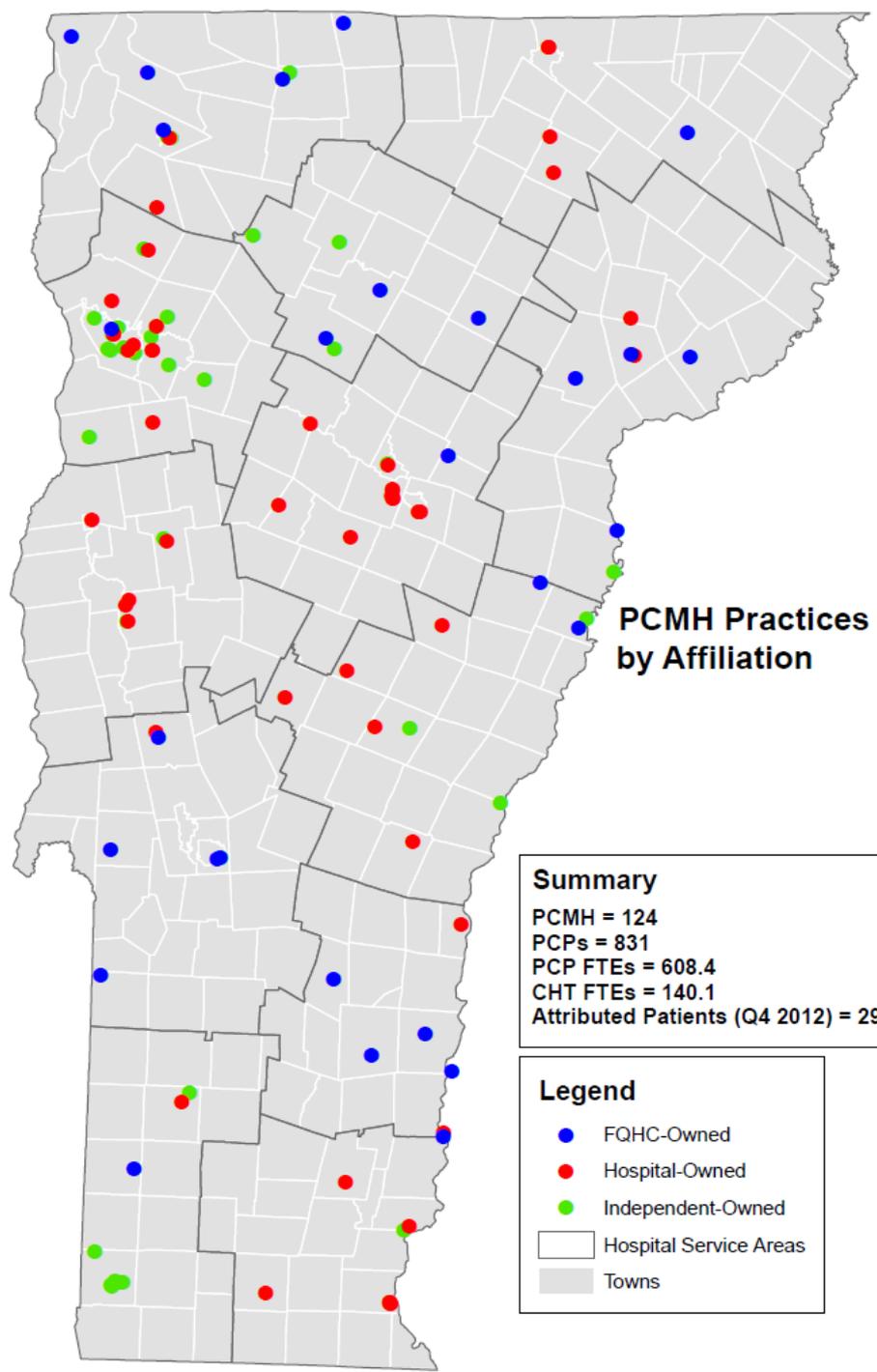
## **Vermont Healthcare Improvement Program Payment Models Workgroup**

**January 16, 2015**



## Health Services Network

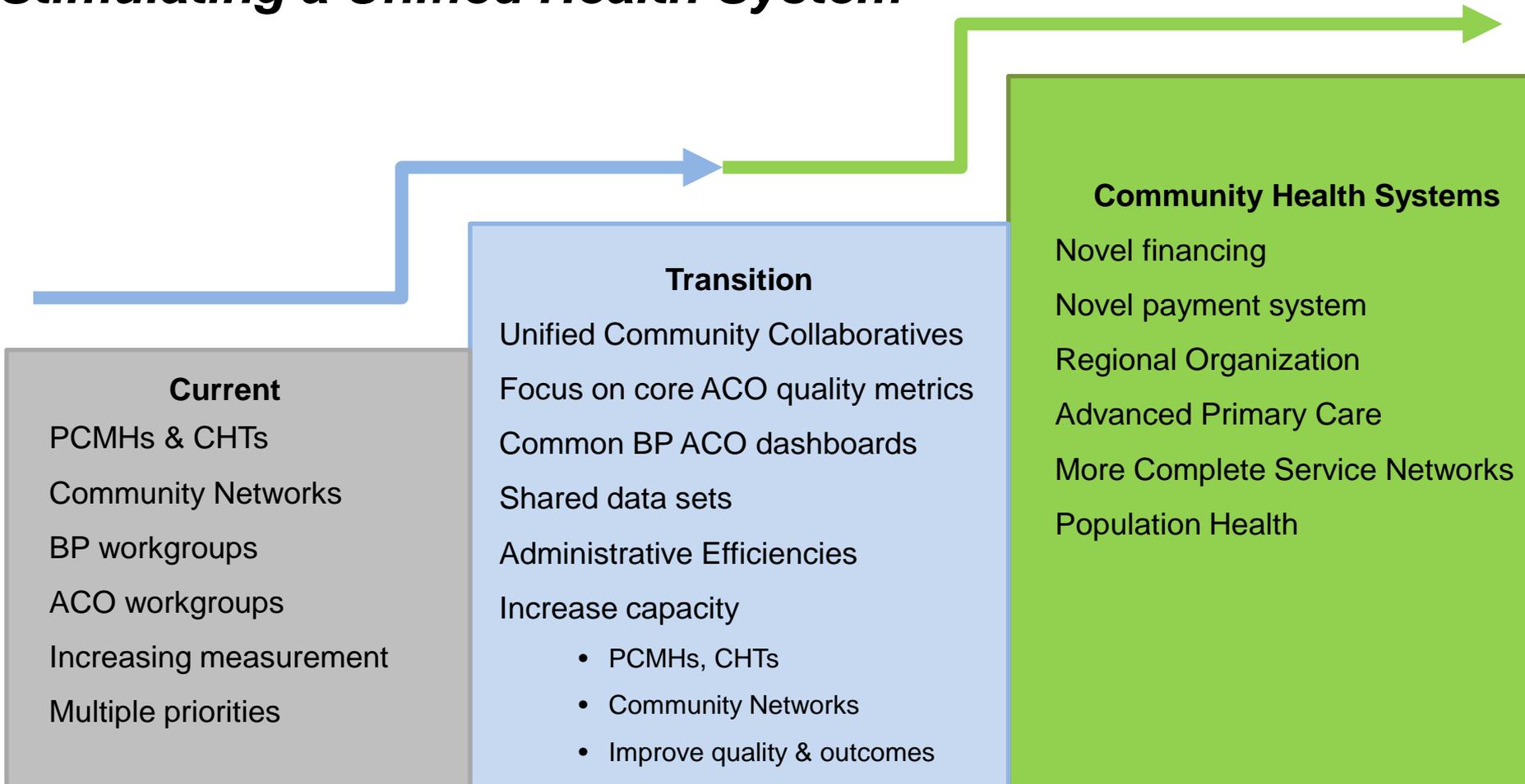
| Key Components                           | July, 2014           |
|--|----------------------|
| PCMHs (active PCMHs)                     | 123                  |
| PCPs (unique providers)                  | 644                  |
| Patients (Onpoint attribution) (12/2013) | 347,489              |
| CHT Staff (core)                         | 218 staff (133 FTEs) |
| SASH Staff (extenders)                   | 60 FTEs (48 panels)  |
| Spoke Staff (extenders)                  | 58 staff (39 FTEs)   |



## Current State of Play

- Statewide foundation of primary care based on NCQA standards
- Statewide infrastructure of team services & evolving community networks
- Statewide infrastructure (transformation, self-management, quality)
- Statewide comparative evaluation & reporting (profiles, trends, variation)
- Three ACO provider networks (OneCare, CHAC, HealthFirst)
- Opportunity to unify work, strengthen community health system structure

# Transition to Green Mountain Care *Stimulating a Unified Health System*



# Strategies for Community Health Systems

## Design Principles

- Services that improve population health thru prevention
- Services organized at a community level
- Integration of medical and social services
- Enhanced primary care with a central coordinating role
- Coordination and shared interests across providers in each area
- Capitated payment that drives desired outcomes

# Strategy for Building Community Health Systems

## Action Steps

- Unified Community Collaboratives
- Unified Performance Reporting & Data Utility
- Community driven quality & coordination initiatives
- Enhanced primary care and community health team capacity
- Modified medical home and community health team payment model
- Administrative simplification and efficiencies

# Unified Community Collaborative (UCC)

## Structure & Activity

- Leadership Team (up to 11 member team)
  - 1 local clinical lead from each ACO (2 to 3)
  - 1 local representative from VNA, DA, SASH, AAA, Peds
  - Additional ad hoc members chosen locally
- Convening and support from local BP project manager/admin entity
- Develop charter, invite participants, set local priorities & agenda

## Unified Community Collaborative (UCC)

### Structure & Activity

- Final recommendations rest with leadership team
- Driven by consensus of leadership team and/or vote process as needed
- Solicit structured input of larger group (stakeholders, consumers)
- Larger group meets regularly (e.g. quarterly)
- Convene workgroups to drive planning & implementation
- Workgroups form and meet as needed (e.g. bi-weekly, monthly)

## Unified Community Collaborative (UCC)

### Structure & Activity

- Use measure results and comparative data to guide planning
- Adopt strategies and plans to meet overall goals & local priorities
- Planning & coordination for service models and quality initiatives
  - guide activities for CHT staff and PCMHs
  - guide coordination of services across settings
  - guide strategies to improve priority measures

# Practice Profiles Evaluate Care Delivery

## Commercial, Medicaid, & Medicare



Practice Profile: ABC P  
Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Welcome to the 2014 Blueprint Practice Profile from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services. Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Practice Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the prior year.

### Demographics & Health Status

|                                    | Practice | H.S.A. | State     |
|------------------------------------|----------|--------|-----------|
| Average Members                    | 4,081    | 84,070 | 2,920,000 |
| Average Age                        | 50.6     | 50.1   | 50.1      |
| % Female                           | 55.6     | 55.5   | 55.5      |
| % Medicaid                         | 14.5     | 13.0   | 13.0      |
| % Medicare                         | 23.7     | 22.2   | 22.2      |
| % Maternity                        | 2.1      | 2.1    | 2.1       |
| % with Selected Chronic Conditions | 50.1     | 38.8   | 38.8      |
| Health Status (CRG)                |          |        |           |
| % Healthy                          | 39.0     | 43.9   | 43.9      |
| % Acute or Minor Chronic           | 18.8     | 20.5   | 20.5      |
| % Moderate Chronic                 | 27.9     | 24.5   | 24.5      |
| % Significant Chronic              | 15.4     | 12.3   | 12.3      |
| % Cancer or Catastrophic           | 1.4      | 1.3    | 1.3       |

Table 1: This table provides comparative information on the demographics & health status of your practice, all Blueprint practices in your Health Service Area (HSA) state as a whole. Included measures reflect the types of information used to adjust rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial enrollment during the year. In addition, special attention has been given to Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's practice, percentage of membership in Medicaid, Medicare eligibility or end-stage renal disease status, and the member requires special Medicaid services that are not found in common populations (e.g. day treatment, residential treatment, case management, services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of members through the claims data as having one or more of seven selected chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, cancer, diabetes, hypertension, diabetes, and depression.

The Health Status measure aggregates 3M™ Clinical Risk Groups (CRG) to the year for the purpose of generating adjusted rates. Aggregated risk class includes: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (e.g., CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (e.g., dystrophy, cystic fibrosis).



Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

### Total Expenditures per Capita

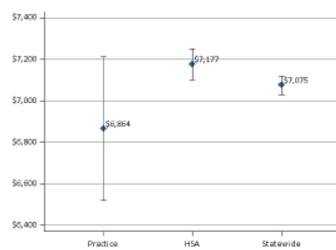


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

### Total Expenditures by Major Category

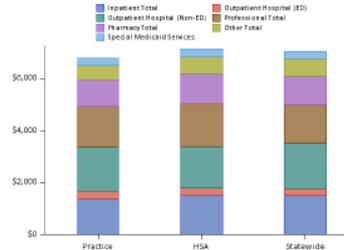


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medical Services.

### Total Expenditures Excluding SMS

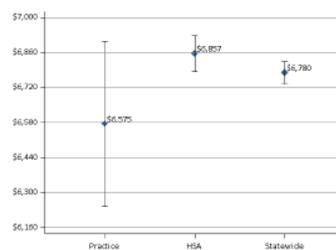


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medical Services capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

### Total Resource Use Index (RUI) Excluding SMS

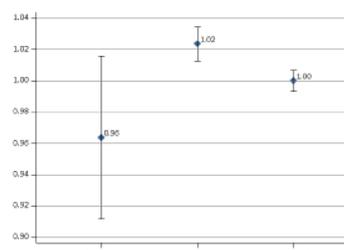


Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per service varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects an aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medical Services. The practice and HSA are indexed to the statewide average (1.00).

Demographics & Health Status Cost of Care Utilization Effective & Preventive Care Data Detail

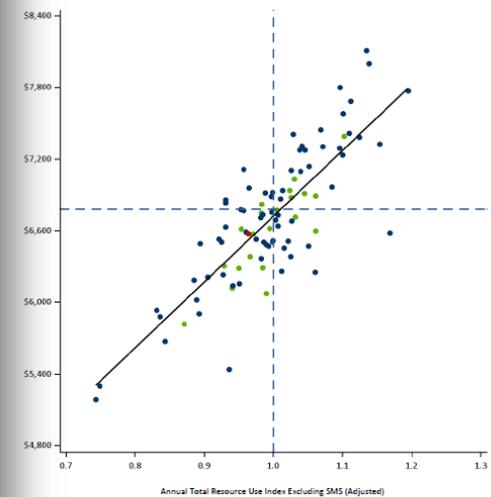
Demographics & Health Status Cost of Care Utilization Effective & Preventive Care Data Detail



Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

### Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)



This graphic demonstrates the relationship between risk-adjusted expenditures excluding SMS and RUI for Blueprint practices. This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint practices (i.e., the blue dots). The dotted lines show the average expenditures per capita and average RUI (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand area with lower expenditures and utilization are in the lower left-hand quadrant. An RUI value indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than average utilization. A trend line has been included in the graphic, which demonstrates that, in general, practices with utilization had higher risk-adjusted expenditures.

Health Status Cost of Care Utilization Effective & Preventive Care Data Detail

# Payment Modifications

## Need for Modifications

- Current payments have stimulated substantial transformation
- Improved healthcare patterns, linkage to services, local networks
- Reduced expenditures offset investments in PCMHs and CHTs
- Modifications are needed for further advancement
- Proposed modifications will support UCCs & quality improvement

# Payment Modifications

## Recommendations

1. Increase PCMH payment amounts
2. Shift to a composite measures based payment for PCMHs
3. Increase CHT payments and capacity
4. Adjust insurer portion of CHT costs to reflect market share

## Proposed Payment Modifications

### Medical Home Payment

- Composite capitated payment (\$PPPM)
- Total = Base + NCQA Rescore + Quality Composite + TUI
- Base payment for participation in UCCs – *practice control*
- NCQA rescore discretionary but rewarded – *practice control*
- Quality component based on HSA results – *interdependencies*
- TUI component based on HSA results – *interdependencies*

## Proposed Payment Modifications

| Current  | Proposed  |
|--|---|
| Targeted Payment   | Composite Payment   |
| <ul style="list-style-type: none"> <li>▪ <i>Single Component</i> – based on NCQA PCMH score. Practice Control</li> </ul> | <ul style="list-style-type: none"> <li>▪ <i>Base Component</i> – participation in UCCs, and NCQA recognition on 2011 standards. Practice Control</li> <li>▪ <i>NCQA Component</i> – rescore is discretionary but rewarded. Practice Control</li> <li>▪ <i>Quality Component</i> – HSA results on a set of core measures. Interdependencies</li> <li>▪ <i>Utilization Component</i> – HSA results on total utilization index. Interdependencies</li> </ul> |
| Incentives for NCQA recognition, a high score on standards, and access to CHT staff.                                     | Incentives for sustained practice quality, access to CHT staff; and coordination with others to improve service area outcomes   |

## Proposed Payment Modifications

| Payment Component         | Eligibility  | Intended Result  |
|---------------------------|--|--|
| Base Payment              | Participation in UCC<br>Recognized on NCQA 2011  | Organize practice and CHT activity to support UCC initiatives                            |
| NCQA Rescore Payment      | Rescore on current NCQA standards (discretionary)  | Maintain medical home quality & operations   |
| Quality Composite Payment | HSA measure results <ul style="list-style-type: none"> <li>• Top 50<sup>th</sup> percentile</li> <li>• Beat benchmarks</li> <li>• Incremental improvement</li> </ul> | Coordinate with others to improve quality and coordination as reflected by core measures |
| Total Utilization Index   | HSA measure results <ul style="list-style-type: none"> <li>• Top 50<sup>th</sup> percentile</li> <li>• Incremental improvement</li> </ul>                            | Coordinate with others to reduce unnecessary utilization and variation                   |

# Proposed Payment Modifications

## Decision Points

- Payment amounts for each component
- Selection of quality & performance measures for composite
- Payment tied to top performance vs. improvement vs. benchmarks
- Payment tied to service area results and/or practice results
- Use of consistent and/or centralized attribution for payment

# Questions & Discussion